Sandwell and West Birmingham Hospitals NHS
NHS Trust

POLICY ON THE HANDLING OF COMPLAINTS

Policy author	Head of Complaints
Accountable Executive Lead	Director of Governance
Approving body	Clinical Leadership Executive
Policy reference	SWBH/ORG/008 [Assigned by Trust policy-Co-ordinator]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – All staff groups

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – All staff groups

POLICY APPROVAL DATE:
26/08/2020

POLICY IMPLEMENTATION DATE:
1 April 2019

DATE POLICY TO BE REVIEWED:
Aug 2023

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
3	12-2007	12-2007	12-2010	Revision to the NHS Complaints Procedure
4	26-11-2009	26-11-2009	26-11-2012	Revision to the NHS Complaints Procedure/ No Changes
4	29-05-2013	29-05-2013	31-08-2013	Extension of review date while policy is being updated.
4	07-10-2013	07-10-2013	31-01-2014	
4	February 2014	February 2014	June 2014	Extension of review date while policy is being updated.
4	August 2014	August 2014	December 2014	
5	12-9-2014	12-9-2014	31-12-2014	Intermediate revision due to change in process.
5	12-01-2015	12-01-2015	31-07-2015	Intermediate revision due to change in process.
6	17-08-2015	17-08-2015	31-12-2015	Intermediate revision due to change in process.
7	31-12-2015	31-12-2015	01-04-2017	Revision of the Policy in view of the merger of the PALS and Complaints Team
8	30-06-2017	30-06-2017	30-09-2017	Review date extended
9	11-10-2017	11-10-17	31-12-2017	Review date extended.
10	26/08/2020	26/08/20	08-08-2023	Revision to policy including Purple Point & new streams for resolving.

Policy on the Handling of Complaints

KEY POINTS

1. A formal complaint is an expression of dissatisfaction requiring a formal written response. A complaint can be submitted face to face, over the telephone, in writing or electronically via email.

2. If a complaint is received in a service area, staff members should attempt local resolution, but advice can be sought from the complaints team, if required.

3. The Trust has processes in place to meet the 30 working day target for responding to complaints. Where the Trust is unable to respond within the agreed timescale, it will inform the complainant of the reasons why and renegotiate the timescale.

4. The Trust investigates concerns raised and responds to complainants in a manner agreed with the complainant. That may be in writing in letter or report format, or in a meeting with a summary letter and a recording of the meeting.

5. Complainants are signposted to advocacy services within the formal acknowledgement letter.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

Contents page

1. INTRODUCTION

1.1 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 require NHS and Local Authority bodies to make arrangements for the handling and consideration of complaints. This policy also meets the requirements of the Local Authority Social Services and National Health Service Complaints [England] Regulations (2009), conforms to the NHS Constitution and reflects the recommendations from the Francis report (2013).

1.2 The Trust has local resolution processes in place such as Purple Point, a telephone line specifically aimed at resolving concerns for inpatients, or Local Resolution (formally known as PALS). If these routes at resolution fail, a formal complaint can be logged.

2. SCOPE

2.1 To provide an easily understood, accessible system for complainants, with a range of solutions to best suit the complainant (local resolution, access to advocacy, formal complaint written response or meeting.)

2.2 To ensure that information on the complaints procedure and complaints responses is made available to complainants in a way that meets their individual needs e.g. a translator attending complaints meetings, sending written information on a CD, or in a large font, or on coloured paper.

2.1 OUT OF HOURS ARRANGEMENTS

2.1.1 Staff in the Complaints Department are generally available from 9am to 5pm Monday to Friday and may be available, by arrangement, at other times for responding to enquiries from complainants. Where complaint staff are unavailable on a given date/ time the enquiry will receive a return call within one working day.

2.2 EXCLUSIONS

The following complaints are excluded from the complaints process:

2.2.1 A complaint made by a local authority, an MP, an NHS body (i.e. CCG, hospital Trust, Foundation Trust), primary care provider (i.e. GP, dentist, optician, pharmacist) or independent provider (i.e. an organisation providing healthcare but who is not an NHS body or a primary care provider) unless they are doing so as an advocate of the patient.

2.2.2 A complaint made by an employee about their employment.

2.2.3 A complaint under investigation by the Ombudsman.

2.2.4 A complaint arising out of the alleged failure to comply with a request for information under the Freedom of Information Act.

2.2.5 Complaints that may relate to issues older than 12 months old.

3. OTHER POLICIES TO WHICH THIS POLICY RELATES

- Trust Incident Reporting Policy.
- Policy for Supporting Staff Involved in An Incident, Complaint, Claim or inquest.
- Policy for the Management of Corporate Records.

- Trust Induction and Mandatory Training Policy.
- Duty of Candour/Being Open Policy

4. GLOSSARY AND DEFINITIONS

4.1 Local Resolution/ Informal complaint - An informal concern, formally known as PALS.

4.2 Devolved complaint – A formal complaint investigated and responded to by the local service facilitated by the Complaints Team.

4.3 Corporate complaint – A formal complaint covering more than one service or organisation, investigated and responded to corporately through the Complaints Team.

4.4 PHSO – Parliamentary Health Service Ombudsman - The Parliamentary and Health Service Ombudsman comprises the offices of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England. The PHSO make final decisions on complaints that have not been resolved by the NHS in England.

5. PRINCIPLES

5.1 How to raise a complaint

5.1.1 Information about giving feedback or making a complaint can be found on the SWB website. A complaint can be made:

- By telephone: 0121 507 6440, or 0121 507 4080 or 0121 507 5892, or via Purple Point or via the 0121 507 5836 PALS telephone number.
- By email: swbh.complaints@nhs.net
- By post to: Head of Complaints, SWB Trust, Sandwell General Hospital, Trinity House, Lyndon, West Bromwich, B71 4HJ.

5.1.2 The Trust endeavors to make any necessary reasonable adjustments in order to receive, investigate and respond to any complaint. For people whose first language is not English, access to translation and telephone interpreting services are available.

5.1.3 Acknowledging communication into the department within 3 working days;

5.1.4 Communicating and outlining issues with the complainant within 5 working days**;**

5.1.5 Communicating case status between day 10-20;

5.1.6 Case closed and response sent in manner requested to complainant within 30 working days, or with an agreed renegotiated response date;

6. WHO MAY COMPLAIN

6.1 A complaint may be made by the person who is affected by the action, or it may be made by a person acting on behalf of a patient; for example if that person is a child (an individual who has not attained the age of 18), if the patient has died, has a physical or mental incapacity or has given consent to a third party acting on their behalf.

6.2 In the case of a child, the Trust must be satisfied that there are reasonable grounds for the

complaint being made by a representative of the child, and furthermore that the representative is making the complaint in the best interests of the child.

6.3 In the case of a person who has died, the complainant must be the personal representative of the deceased. SWB needs to be satisfied that the complainant is the personal representative. Where appropriate, we may request evidence to substantiate the complainant's claim to have a right to the information requested.

6.4 In the case of a person who is unable by reason of physical capacity, or lacks capacity within the meaning of the Mental Capacity Act 2005, to make the complaint themselves, SWB need to be satisfied that the complaint is being made in the best interests of the person on whose behalf the complaint is made.

6.5 In the case of a third party pursuing a complaint on behalf of the person affected we will request the following information:

- Name and address of the person making the complaint;
- Name and either date of birth or address of the affected person;
- Contact details of the affected person so that we can contact them for confirmation that they consent to the third party acting on their behalf; and
- Their relationship to the affected person.

6.6 These records will be documented in the complaint file and confirmation will be issued to both the person making the complaint and the person affected. In addition, where an affected person:

- Has delegated authority to act on their behalf, for example in the form of a registered Power of Attorney which must cover health affairs;

- Is an MP, acting on behalf of and by instruction from a constituent;

6.7 Proof of any Power of Attorney documentation will be requested and held as evidence on the complaint file.

6.8 Where a complaint is raised with regard to a potential serious incident that may be subject to Duty of Candor regulations, the Complaints Team will liaise with the Patient Safety Team to decide which is the most appropriate type of investigation, and how the complainants questions can be accommodated and responded to. The outcome will be fed back to the complainant, that either 1) an RCA investigation will be undertaken, and the complaint closed and feedback provided in either written or verbal format, or 2) a complaint investigation will be undertaken with a meeting or written response being provided. Any Duty of Candor processes will not be undertaken by the Complaints Team, rather the clinical service will undertake these responsibilities.

7. TIME LIMIT

7.1 A complaint must be made within 12 months after the date the subject matter of the complaint occurred, or the date the subject matter of the complaint came to the notice of the complainant. Complaints raised after this timeframe will be logged at the explicit discretion of the Head of Complaints if provided with a reasonable explanation for the delay.

8. DEALING WITH HABUTUAL OR VEXACIOUS COMPLAINANTS

8.1 See Appendices 2 & 4 for guidelines for meeting with complainants and dealing with

complainants over the telephone and for dealing with habitual or vexatious complainants.

9. SUPPORT FOR STAFF

9.1 Guidance is available in the Trust's Policy for Supporting Staff Involved in An Incident, Complaint, Claim or inquest.

9.2 Independent and confidential support can also be obtained from the external organisation commissioned to provide employee support, benefit and advice (OH - Occupational Health Service) 0121 507 3306, or via email to swbh.ohreferrals@nhs.net

10. ROLES AND RESPONSIBILITIES

10.1 Trust Board -To receive assurance regarding the implementation of the complaints policy and to receive and consider quarterly and annual reports on the handling of complaints.

10.2 Chief Executive -To be accountable overall for the complaints process and to either sign all responses for written complaints or delegate a signatory as appropriate.

10.3 Director of Governance -To ensure compliance with the policy for handling complaints and to that action is taken as a result of an outcome of any investigation, and that lessons are shared across the Trust.

10.4 Head of Complaints - Responsible for the overall management of complaints across the Trust, playing a key role in ensuring the quality and consistency of responses and that the Trust has effective systems and processes in place so that complaints are robustly investigated, and patient feedback informs learning and service improvements.

10.5 Deputy Head of Complaints - To deputise for the Head of Complaints in relation to attendance on committees, operational HR issues and escalated complainant enquiries in the Head of Complaints absence.

10.6 Investigation Lead (allocated Clinical Group/ Corporate Directorate Manager or Complaints Manager) - Investigate and resolve complaints in relation to wards, services or departments that fall under their remit to ensure that a fair, robust, open, transparent proportionate response is provided by the Trust.

10.7 Group Managers (for complaints managed in the corporate or devolved process) - Ensure that any recommendations for service improvement falling under their remit arising from complaints are acted upon, or referred to an appropriate person for action. Actions relevant to other areas should be highlighted Trust-wide.

10.8 Complaints Coordinator -Provide support to the Complaint Investigation Leads to ensure that the investigation progresses in a timely and efficient manner, provide key performance information to the Groups they support.

10.9 All staff -To be aware of the requirements of the complaints policy and the role that all members of staff have in dealing with complaints. To deal with complaints on the spot or not later than the next working day, by giving the complainant reassurance and responding sympathetically, openly and transparently - A speedy response could prevent a minor problem from becoming a major complaint.

10.10 Group Directors of Operations/Executive Director/Clinical Directors -To monitor arrangements for local complaints handling e.g. compliance with performance targets and

timescales, the recording of informal complaints. To consider trends in complaints and the links between reported incidents and staffing, to circulate complaint responses to the relevant staff within their Group/Directorate and to consider lessons to be learned from complaints and develop action plans.

11. PROCEDURE

11.1 Please refer to Appendix 1 flow charts A, B, C & D for the procedure for management of complaints.

12. CONSULTATION

12.1 Consultation is undertaken by engaging with the Local Interest Group and Equality and Diversity Committee and all staff groups.

13. AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

13.1 Monitoring of compliance and effectiveness of this policy will be the responsibility of the Head of Complaints. This will include:

- Monitoring of robust KPIs as listed below for the department, and escalating concerns to the Chief Executive / Director of Governance as appropriate:
- Acknowledging communication into the department within 3 working days;
- Communicating and outlining issues with the complainant within 5 working days;
- Communicating case status between day 10-20;
- Case closed within 30 working days, or with an agreed renegotiated response date; Preparing quarterly and annual reports for the Trust Board;
- Preparing monthly reports for the Clinical and Corporate Governance Groups;
- Reviewing feedback from the Parliamentary Health Service Ombudsman on complaint handling;
- Reporting on themes and learning from complaints on a monthly and quarterly basis;
- Reviewing feedback and feedback methods from complainants via the feedback questionnaire;
- Monitoring completion of actions from complaints and reporting on these on a monthly basis;
- Monitoring and auditing completed actions from complaints via evidence based audits.

14. TRAINING AND AWARENESS

14.1 Details of the training requirements are contained within the Training Needs Analysis, located on the Trust Intranet.

14.2 Training is available:

- To increase staff awareness of the importance of responding well and in a timely manner to complaints;
- Develop the necessary communication skills so that staff are adequately equipped to respond to the complainant's needs and can prevent a minor problem from becoming a major complaint.

15. EQUALITY AND DIVERSITY

15.1 The Trust recognises the diversity of the local community and those in its employment. Our

aim is therefore to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their needs. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this. All policies are assessed in accordance with the Equality Impact Assessment Toolkit, the results of which are monitored centrally.

16. REVIEW

16.1 This policy will be reviewed in three years' time unless an earlier review is required.

17. REFERENCE DOCUMENTS AND BIBLIOGRAPHY

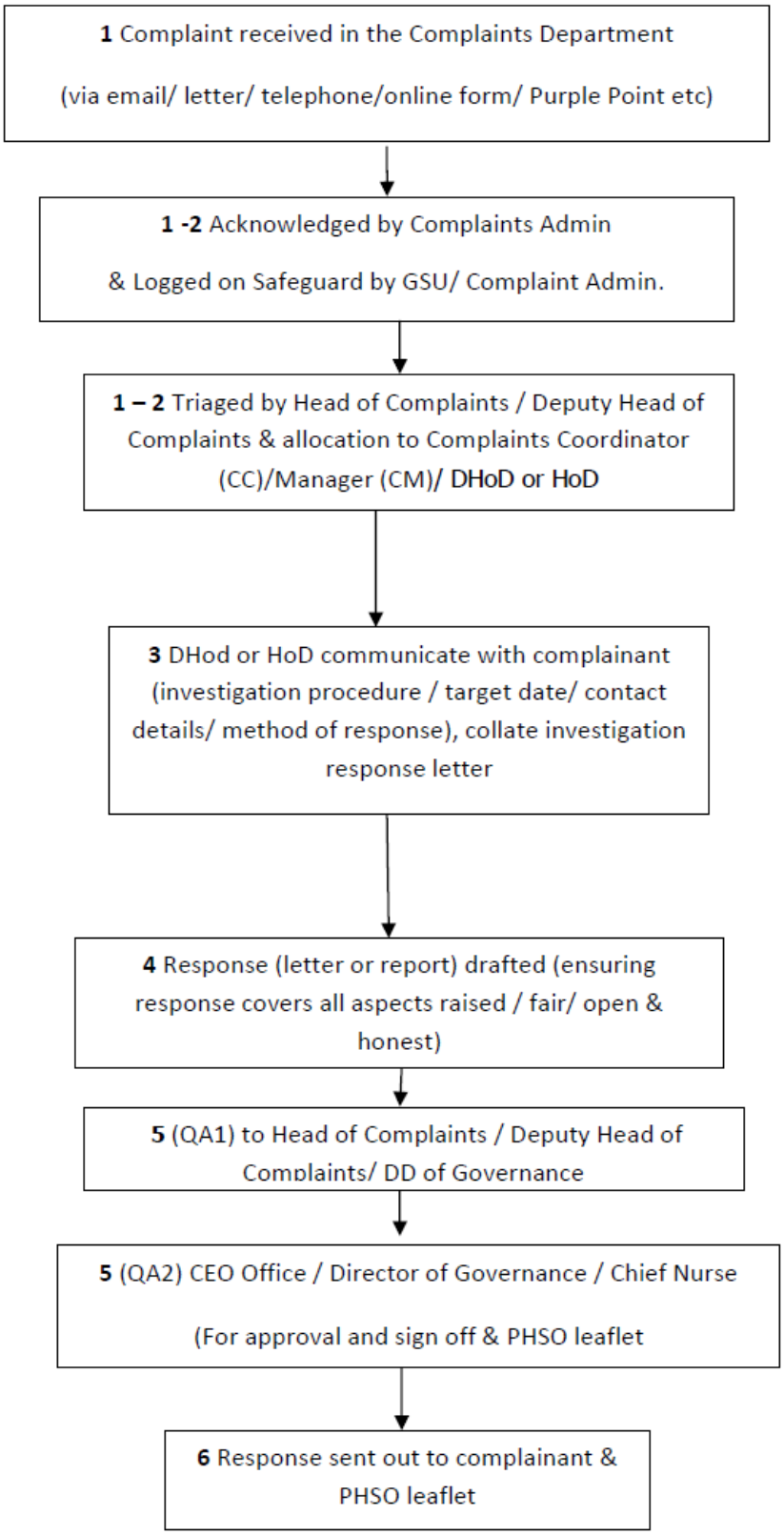
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009;
- Trust Incident Reporting Policy;
- Parliamentary Health Service Ombudsman (PHSO) & Healthwatch report "My Expectations" 2014;
- PHSO Principles of Good Complaints Handling (2009);
- The NHS Constitution;
- Trust's Policy for Supporting Staff Involved in An Incident, Complaint, Claim or inquest.

18. FURTHER ENQUIRIES

Further information relating to this policy can be obtained from the Head of Complaints.

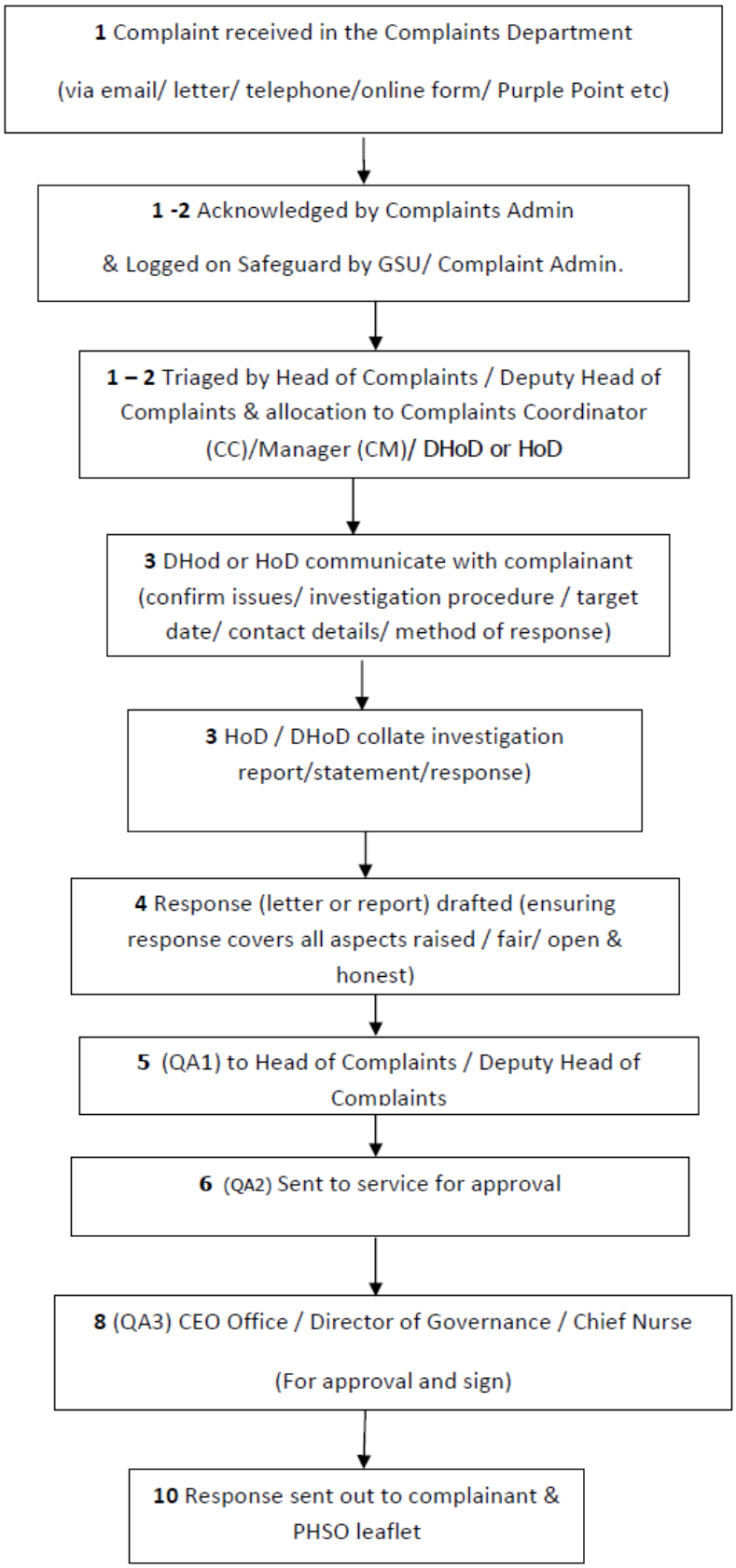
Process A for Investigating Complaints

(max 10 working days)



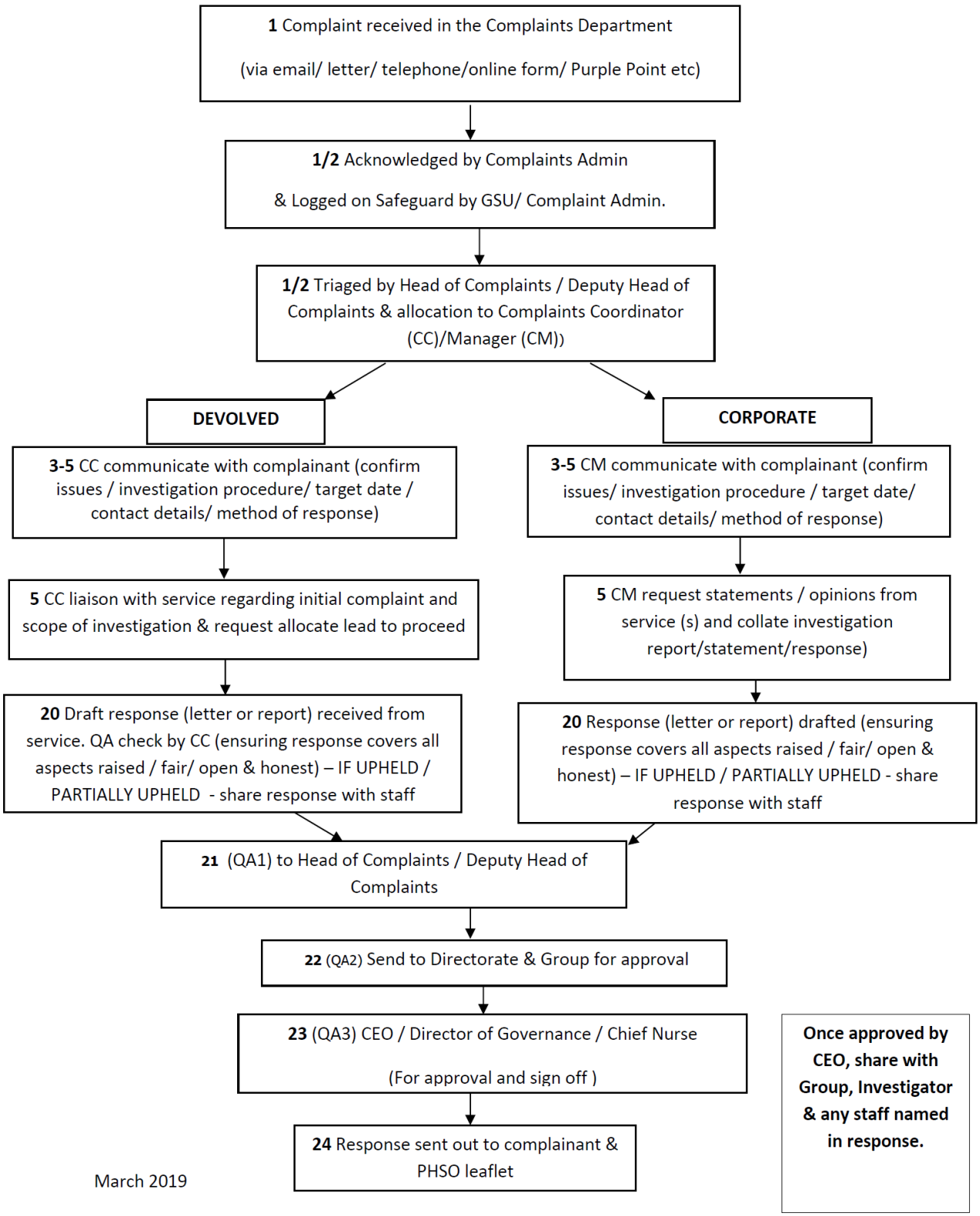
Process B for Investigating Complaints

(timescale 15 working days)



Process C for Investigating Complaints

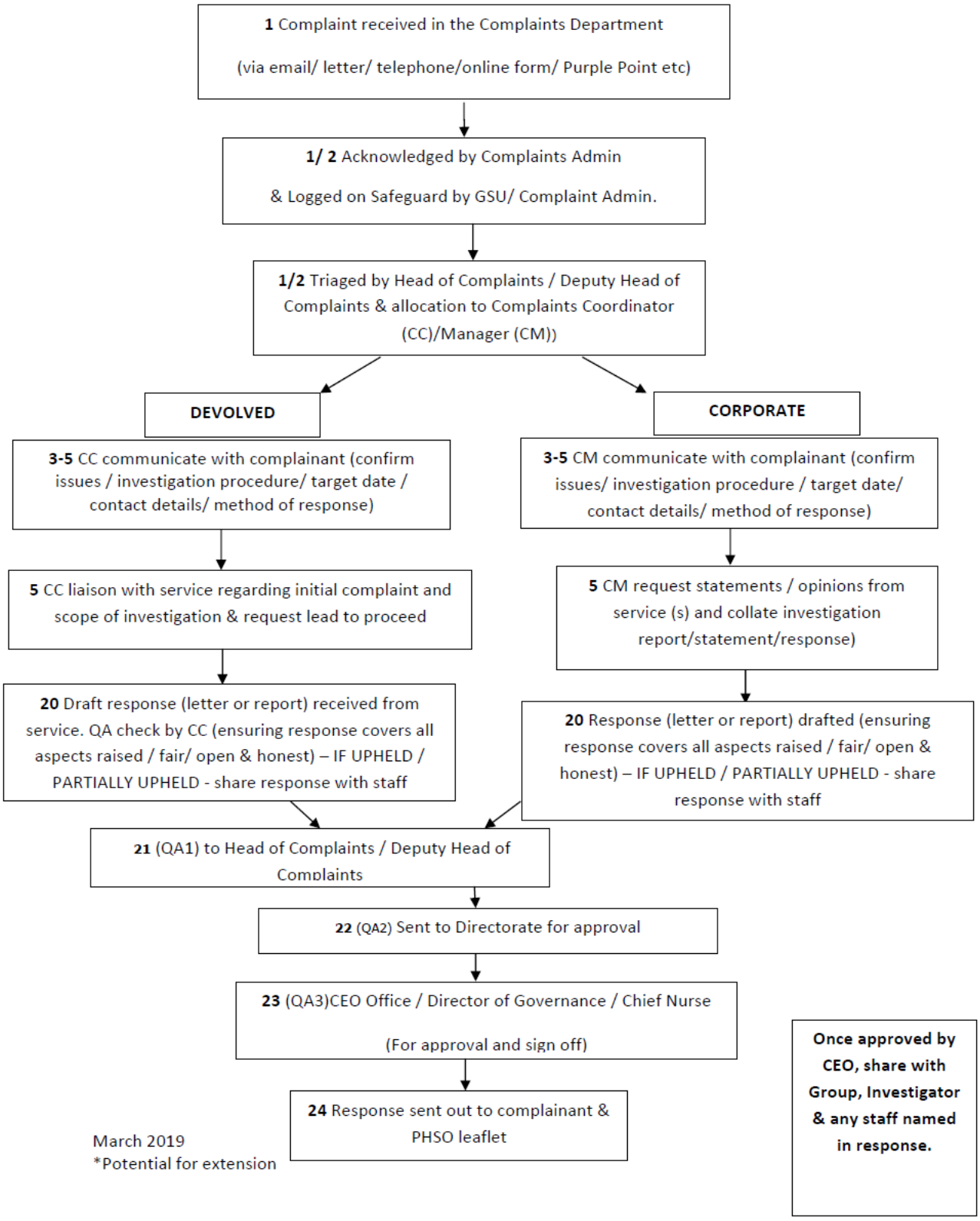
(timescale 30 working days)



March 2019

Process D for Investigating Complaints

(timescale 30* working days)



March 2019
*Potential for extension

Appendix 2

GUIDELINES FOR MEETING WITH COMPLAINANTS AND DEALING WITH COMPLAINANTS OVER THE TELEPHONE

1.0 Introduction

These guidelines have been developed to demonstrate what an appropriate environment is for a meeting and to consider safe systems of working and how to deal with complainants over the telephone, particularly those who may be verbally abusive and/ or aggressive.

These guidelines are not all encompassing and are intended primarily to raise staff awareness on the possible risks when meeting with complainants. It is recognised that at ward/department level staff very often meet with complainants on an unplanned basis. However, local arrangements can still be in place for dealing with such situations, such as agreeing a designated room for meeting with complainants and, particularly, safe systems of working.

2.0 Aims - To ensure the safety of staff at all times whilst meeting complainants.

2.1 To ensure staff are aware of what actions they can take when dealing with complainants over the telephone who are verbally abusive and aggressive.

3.0 Objectives - To ensure the environment in which complainants are met is as conducive as possible.

3.1 To ensure staff recognise the importance of safe systems of working.

3.2 To ensure staff facilitate dealing with complainants over the telephone.

4.0 Meeting with Complainants - What to Consider?

4.1 Environment - Ideally meetings will be scheduled and there will therefore be time to arrange the environment in which you meet complainants, although in ward/department areas meetings are very often unplanned.

1.1.1 Location

Is there any risk of the complainant returning unannounced? If you feel this might be a possibility, you should consider arranging the meeting away from your area of work.
Is the room of sufficient size? Consider the size of the group you are meeting, bearing in mind that often more relatives attend than are expected. Where is the room located? Ensure it is not isolated.

4.2 Safe Working

It is important to remember staff safety and security at all times. Whether meetings are scheduled or unscheduled, always consider the following points:

4.2.1 As far as possible DO NOT meet complainants on your own, even if you are meeting only one person. It is, however, understood that this may be unavoidable and so a risk assessment of the area, and contingencies plans should be put in place.

4.2.2 Always ensure someone knows where you are and who you are with.

4.2.3 Arrange for someone to check on you after an agreed period of time — this is especially important if you have to meet someone on your own.

4.2.4 If you feel a situation could get out of hand, make an excuse to leave the room for a short period of time to allow both parties time to calm down.

4.3 Meeting with Complainants in their own homes

When meeting complainants in their own homes, it is difficult to control the environment. However, you may still be able to control the environment to some degree, such as where you sit in a room and therefore what barriers are between you and the complainant. You can also ensure safe systems of working by following 4.2.1 to 4.2.3 above.

5.0 Dealing with Complainants over the Telephone

Whilst the majority of complainants who contact the Trust by telephone will be civil and polite, a small minority could be verbally abusive and/or aggressive. They may attempt to pursue a complaints in a manner which is deemed to be unreasonably persistent, abusive or even vexatious. Similarly, from time to time complainants may seek to maintain a relentless communication via the raising of serial complaints or a persistent continuation of a complaint that has been dealt with. This can be extremely upsetting for the member of staff taking the call and it is therefore important that staff are aware of what they can do in such a situation. This guidance can also be followed when receiving calls from anyone who becomes abusive and/or aggressive.

5.1 Examples of such behaviour may include: the persistent pursuit of unrealistic outcomes or demands; attempts to access confidential information, persistently unreasonable (and sometimes aggressive or abusive) behaviour towards the organisation's staff in respect of a complaint or multiple complaints; excessive and disproportionate requests for information in respect of a complaint or multiple complaints; persistent attempts to have complaints which are well out of time investigated, or to have complaints which have previously been the subject of investigation and which may have also been considered by the Parliamentary Health Service Ombudsman reinvestigated.

5.2 Therefore the Trust has procedures in place to deal with Persistent, Serial or Vexatious complainants in order to ensure that there is equity, fairness and consistency in our response to contacts of this type. It will not always be the case that a complainant who is persistent in their contacts or who raises a number of complaints should be dealt with via this procedure. The Trust believes that the decision to apply the procedure for dealing with a complainant as a persistent, serial or vexatious complainant should be taken only as a last resort and on a case by case basis. However, in a small number of cases the Trust will use such procedure to limit or restrict an individual's access to the Complaints Process.

5.3 In the event that a decision is taken to limit or restrict a complainant's access to the Complaints Process, then they will be informed, in writing. This letter should detail the steps that the organisation has taken in order to attempt to resolve the matter and the nature of the persistent unreasonable or vexatious behaviour being demonstrated by the complainant and details of the restrictions to be put in place. All such letters will be approved and signed by the Director of Governance or in their absence the Deputy Director of Governance.

5.4 If a complainant becomes either verbally abusive or aggressive, inform them in a calm, civil voice that verbal abuse/aggressive behaviour is not acceptable. Remind the caller that you are trying to help, and as such if the manner continues, you will end the call. See additional guidance in appendix 4.

5.5 If the complainant continues, end the call.

5.6 Immediately following the call you should inform your line manager, giving the complainant's name, any details you have taken regarding the complaint they were making and details of their behaviour and the action you took before putting the receiver down. Also discuss the action you should take if the complainant makes contact again. In some cases it may be appropriate to notify your Departmental Manager or Head of Complaints.

5.7 If the call has been particularly upsetting, if you can, take time away from your desk, have a drink or talk it over with your with colleagues (without giving details of the caller in question).

5.8 Complete a non-clinical incident form and make a file note of the conversation to the best of your recollection.

6.0 Training

6.1 All staff should be conversant with the Trust's policy on "Violence and Aggression"

6.2 Requirements for further training should be identified during the annual violence and aggression risk assessments undertaken by senior managers.

7.0 Monitoring and Audit

Monitoring will take place as part of the annual health and safety report for each area and the violence and aggression risk assessments for staff.

8.0 Financial Implications

There may be financial implications arising from training requirements identified outside those already identified within the Violence and Aggression Policy**.**

Appendix 3

GUIDELINES ON WRITING STATEMENTS FOR INCIDENT REVIEW AND COMPLAINT INVESTIGATION

1.0 Introduction

The Trust does not seek to apportion blame whilst investigating complaints and aims to ensure that any complaints are investigated transparently, concentrating on the causes of incidents, so that lessons are learned. This enables the Trust to reduce risks and improve the care it delivers. You will be asked in writing for a statement if you are involved in a complaint investigation.

The statement from a member of staff following a complaint is a written record of events that occurred. When all the information is put together, the outcome should be that the events leading to the incident have been clearly defined and any latent system failures can be identified.

Reports prepared for a specific complaint will contribute towards the final response to the complainant from the Chief Executive. The report will be confidential but may be sent to the Coroner (if appropriate) or to the Parliamentary Health Service Ombudsman should the complainant remain dissatisfied. Any subsequent Ombudsman enquiry may ask questions about the content of any staff statement.

2.0 Aim

To provide written guidance for staff on how they should write up statements and summaries of discussion.

3.0 Objectives & content of statement

The key task required of every factual witness is to assist the enquiry with evidence in the form of a statement that is:

- Factual, i.e. no opinion or guesses about provision of care;
- Accurate, e.g. refer to relevant contemporaneous records;
- Relevant, avoid blaming or judging others or including areas in your statement you have not been involved in.
- Identify the concerns that have been raised. It is often helpful to set out an account of what took place, even if this is background information, but do not lose sight of the issues.

- The purpose of the response is to establish the facts and add to the whole picture.

- Avoid Jargon — use plain English.

- The response should be typed, so that it is clearly legible.

4.0 Confidentiality

Confidentiality is important and care should be taken to ensure only those who will be involved and implementing actions for the Trust read the statement. It is important to learn lessons and the essential information from the cases involved will be anonymised for lessons to be learned. Statements should, therefore, be headed ‘Confidential’ and addressed to the requesting individual. A heading is helpful, something like ‘Report concerning……By…….

4.1 Biography of writer

The first few lines may be a potted biography of the writer's role to put into context for the reader. Where appropriate, a summary of the patient's condition and principal symptoms being treated is a useful start. A defined period of time must be known for the report, it may be from admission or it may be for a few hours if that is all you have been involved in. It is important that the statement only refers to the writer's input in this respect.

4.2 Team Members involved in the provision of care

The provision of care is never delivered by one person alone, so it is important to establish the team members involved in provision of care eg Medical Staff, Consultant(s) speciality, Nursing Team, skill mix on duty for episodes of care, therapy involvement. The statement should state who was working and what their involvement was in the decision making, and the delivery of care. This must be factual.

4.4 Chronology of events

Establish a chronology of events through establishing the roles of the members of staff as a whole and record the limits of your involvement. The first step in the analysis is to produce an agreed history of events (check with the person requesting the report as some of this may have already been prepared). The starting point will be the point at which the patient entered the hospital. As part of a team, it is important to demonstrate the hand over procedures employed for continuing care provision.

4.5 Care Management

State the tools employed in the provision of the care provided and the outcomes of that care management should be also be stated eg Risk Assessments (Falls/Pressure Sore), Care Pathways. Copies of the assessments may be added to the report where appropriate.

4.6 Contributory Factors

You will find it useful to identify any care management problems and the relevant actions undertaken at the time to remedy the problems encountered.

5.0 Sources

Any sources such as standards, policies, audits recommendations, incidents and will all add to the thoroughness of a statement.

Appendix 4

GUIDELINES ON HOW TO IDENTIFY AND MANAGE HABITUAL/VEXATIOUS COMPLAINANTS/COMPLAINTS

All complaints should be processed in accordance with the NHS complaints procedure. However, during this process, staff may have contact with a small number of complainants who absorb a disproportionate amount of resources whilst dealing with their complaints.

In determining how to identify situations where the complaint might be considered to be habitual or vexatious, how to respond to these situations and how to appropriately manage such complaints, the following must be considered:

- That the complaints procedure has been correctly implemented so far as is possible and that no material element of a complaint has been overlooked. It must be appreciated that what can seem as habitual or vexatious complaints may have aspects that contain genuine substance.
- That an equitable approach has been followed.

Definitions

Complainants may be deemed to be habitual or vexatious, where previous or current contact with them shows that they meet two or more of the following criteria:

- Persist in pursuing a complaint when the NHS complaints procedure has been fully and properly implemented and exhausted (e.g. When an investigation has been denied as 'out of time', where the Ombudsman has declined a request for independent review).

- Change the substance of a complaint, or continually raise new issues, or seek to prolong contact by continually raising further concerns or questions upon receipt of a response, or whilst the complaint is being addressed.

- Are unwilling to accept documented evidence of treatment given as being factual, e.g. Drug Records, hand-written or computer records, nursing records, or deny receipt of an adequate response, despite correspondence specifically answering their questions, or they do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues they wish to be investigated, despite reasonable efforts of staff to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.

- Focus on a trivial matter, to an extent that it is out of proportion to its significance and continue to focus on this point (it is recognised that determining what is 'trivial', can be subjective and careful judgement must be used in applying this criterion).

- An excessive number of contacts with the Trust, in the course of addressing a formally registered complaint, placing unreasonable demands on staff (a contact may be in person or by telephone, letter, for email and it is at the Head of Complaints discretion as to what determines the precise number of 'excessive contacts').

- Have harassed or deemed to be abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint. However, it must be recognised that complainants may sometimes act out of character at times of stress, anxiety or distress and reasonable allowances for this may be allowed (all incidents of harassment must nonetheless be documented and logged).

• Have threatened or used actual physical violence towards staff at any time. This will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will thereafter only be pursued through written communication (all such incidents must be documented and logged).

• Known to have recorded meetings, face-to-face or telephone conversations without the prior knowledge and consent of the other parties involved.

• Display unreasonable demands/expectations and fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or usual recognised practice).

Options for dealing with habitual/vexatious complainants

Where complainants have been identified by the Head of Complaints as being habitual or vexatious, in accordance with the above criteria, the complainant will be notified by writing from the Director of Governance or the Deputy Director of Governance in their absence. This notification may be copied for information of others already involved in the complaint. A record must be kept for future reference, of the reasons why a complainant has been classified as habitual or vexatious**.**

The Director of Governance may decide to deal with complaints in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed 'agreement' with the complainant, which sets out a code of behaviour for the parties involved if the Trust is to process the complaint. If these terms are contravened, consideration would then be given to implementing other actions as indicated in this section.
- Once it is clear that the complainants meet any one of the criteria above, they should be informed in writing that they may be classed as habitual or vexatious complainants. The policy should be copied to them and they should be advised to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest that complainants seek advice in processing their complaint, e.g. through an advocacy service.
- Decline any contact with the complainants either in person, by telephone, by e-mail, by letter or any combination of these, provided that one form of contact is maintained or alternatively to restrict contact to liaison through a third party.
- Notify the complainant in writing that the Director of Governance has responded fully to the points raised and has tried to resolve the complaint, but there is nothing more to add and continuing contact will serve no purpose. The complainants should also be notified that correspondence is at an end and that further letters received will be acknowledged but not answered.
- Inform the complainants that in extreme circumstances, the Trust reserves the right to pass unreasonable or vexatious complainants to the Trust's solicitors and/or to the police, if physical violence is threatened.
- Temporarily suspend all contact with the complainants or investigation of a complaint whilst seeking legal advice or guidance from the Trust Commissioners, or other relevant agencies.

Withdrawing 'Habitual or Vexatious' Status

Once complainants have been determined as 'habitual or vexatious', the mechanism for withdrawing this status if complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures appear appropriate, will be considered objectively and assessed on merit at least on a yearly basis.

Staff should previously have used discretion in recommending ‘habitual or vexatious’ status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Director of Governance (or their deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.